

SUMMARY PLAN DESCRIPTION – AFSCME PPO Plan

Effective July 1, 2015

Introduction

Ohio University maintains the Ohio University AFSCME PPO Plan for the exclusive benefit of its eligible employees and their eligible and dependents. The Plan is intended to provide health care benefits to eligible employees and their families.

Your health care benefits are described in the plan benefit booklet.

This document together with the benefit booklet constitute the Summary Plan Description (the “SPD”).

Eligibility and Participation Requirements

Eligible Employees: Ohio University reserves the right to change, modify or terminate any or all of the benefits, in whole or in part, including but not limited to, benefit structure, copayments and deductibles, at its discretion, with or without notice. Any such amendment or termination shall be by a written instrument, executed by an executive of the university.

Ohio University shall have discretionary authority to determine an individual's eligibility for benefits under the plan and to construe, interpret and apply the terms and conditions of the Plan. Ohio University's determination, construction, or interpretation shall be final and conclusive.

Benefits are based upon the written terms of the Summary Plan Description and plan document. This summary is intended to provide you with an easy to understand explanation of the plan. Any informal communications, oral or written shall have no effect and shall in all cases be superseded by the written terms of the Summary Plan Description and plan document. If any conflict should arise between the explanation in this summary and the terms of the plan document, or if any provision regarding these coverages is not described or only partially described in this summary, the terms of the plan document shall govern. If the terms of plan document are insufficient regarding a coverage issue, the standard medical policy of the university's Third Party Administrator (TPA) shall govern.

Some of Ohio University's contracts with insurers, TPA, and or providers allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the benefit of Ohio University and Ohio University will retain any payments resulting therefrom.

Eligible employees include:

- Full-time and Part-time employees covered by the collective bargaining agreement between Ohio University and Local 1699 & Ohio Council 8 AFSCME, AFL-CIO..
- Any AFSCME member who qualifies for health insurance coverage as dictated by State and Federal law, including the Patient Protection and Affordable Care Act. Individuals who qualify due to the Patient Protection and Affordable Care Act are eligible for benefits as long as required by the Affordable Care Act.
- AFSCME members eligible as described by university policy or bargaining agreement due to a reduction in force, a non-renewal, or due to a severance agreement.

Cost of Coverage

Employee premiums are required and available from Human Resources. Ohio University reserves the right to raise the cost of coverage.

Eligible Dependents

An Eligible Dependent is your married spouse while not divorced from you, your qualified same or opposite sex domestic partner, each child from birth to age 26 under regular family premiums and ages 26 and 27 for additional premiums, as required and allowed by state and federal law, and children declared disabled by the university TPA. Children include biological children, step-children, adopted children, children for whom you have legal custody, and children of your qualified domestic partner. Human Resources requires proof of dependent status, such as birth certificates an marriage licenses, and/or affidavits regarding domestic partnerships.

HOW TO ENROLL

Enrollment materials for medical, dental, vision and prescription drug coverage will be provided to eligible employees upon commencement of employment. Coverage for these health care benefits will begin on your date of hire. You must complete a health care enrollment application and submit required dependent verification documentation within 31 days of your date of hire in order for your coverage to become effective; otherwise you must wait until the next open enrollment period to enroll. Enrollment applications missing required dependent verification documentation will be suspended pending submission of required documentation. Once documentation is received coverage for a dependent will begin at date of hire. If you fail to provide required documentation for a dependent within 31 days of your date of hire, the dependent will not be enrolled and you must wait until the next open enrollment period to enroll the dependent. Spouses and eligible age children may remain on the plan for a period of five years upon the death of an enrolled employee.

This plan does not contain any pre-existing condition limitation exclusions.

Your Identification Card

You will receive identification cards. These cards have your name and identification number on them. The identification card should be presented when receiving Covered Services under this coverage because it contains information you or your Provider will need when submitting a claim or making an inquiry. Your receipt or possession of an identification card does not mean that you are automatically entitled to benefits.

Your identification card is the property of Ohio University and must be returned if your coverage ends for any reason. After coverage ends, use of the identification card is not permitted and may subject you to legal action.

ADDITIONS AND DELETIONS OF ELIGIBLE DEPENDENTS FOR HEALTH COVERAGE

The following enrollment procedures apply for adding and deleting eligible dependents. Any changes affect all applicable coverages (i.e., health, dental, and vision). Employees must contact University Human Resources for the appropriate forms.

Qualified Family Status Changes

You may change your elections (i.e., switch from single to family coverage or vice versa) during a plan year if you have a Qualified Family Status Change that includes:

- Marriage, divorce or legal separation; (Your spouse's coverage will be effective as of the date of marriage), termination of a domestic partnership;
- Death of a spouse, domestic partner, or child;
- Birth, adoption, or commencement of legal guardianship of a child;

(Your child's coverage will be effective as of the date of birth or as of the date the child is placed for adoption or as of the date the legal guardianship commences. Coverage will continue for an adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.)

- Commencement or involuntary termination of spouse's or domestic partner's employment;
- Switching from part-time to full-time status by the employee or spouse or domestic partner;

- Significant changes in the health care coverage of the employee or his/her spouse or domestic partner attributable to the employee's or spouse's employment or employment status.
- Termination of coverage of an eligible dependent, such as a child reaching the maximum age for coverage under the plan.

Special Plan Year 2013-2014 Mid-Year Election Changes Due to Patient Protection and Affordable Care Act (ACA): An employee may make a one-time change to their plan year 2013-2014 health insurance enrollment (begin coverage, change coverage tier, or drop coverage) to comply with the ACA individual coverage mandate or due to obtaining health insurance coverage through a State public health exchange.

Ohio University must be notified when you or an Eligible Dependent becomes eligible for Medicare.

NOTE: Additions must be made within 31 days of a Qualified Family Status Change; otherwise you must wait until the next health care Open Enrollment Period. If the necessary documentation is provided within 31 days of the Qualified Family Status Change, coverage will be effective as of the date of the Qualified Family Status Change. Deletions must be made within 31 days of the Qualified Family Status Change. Once you have reported a Qualified Family Status Change, you will be provided with the required forms or online method to add or delete eligible dependents. Required documentation may also be requested by Ohio University's insurer/third party administrator. COBRA continuation coverage will be offered to the eligible dependent(s) by Ohio University's COBRA administrator.

SPECIAL ENROLLMENT PROVISIONS

- If you decline enrollment for yourself or your dependents (including your spouse) when you are first eligible to enroll, because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. This special rule applies if you or your dependents lose the other coverage due to termination of employment, change in employment status, termination of the other plan's coverage, cessation of the employer's contribution toward coverage, exhaustion of COBRA coverage, death of a spouse, or divorce;
- If you have a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, or commencement of legal guardianship, you may be able to enroll yourself and your dependents, provided that you request enrollment and provide required dependent verification documentation within 31 days after the qualifying event. If you are eligible for coverage but do not enroll, your dependent cannot enroll.

CHANGING COVERAGE

You may change your elections during the annual open enrollment period, which is currently held in the Spring of each year. Coverage changes are effective as of July 1, or such other date as Ohio University may specify.

NOTE: New employees may change their coverage election within 31 days of their hire date.

Qualified Medical Child Support Order

In general, a Qualified Medical Child Support Order (QMCSO) is a court order that requires an eligible employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. A QMCSO may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This Plan provides benefits according to the requirements of any QMCSO as defined by ERISA section 609(a). Ohio University will promptly notify affected participants and alternate recipients if a QMCSO is received. Ohio University will notify these individuals of its procedures for determining whether medical child support orders are qualified; within a reasonable time after receipt of such order, Ohio University will determine whether the order is qualified and notify each affected participant and alternate recipient of its determination.

Once the dependent child is enrolled as an alternate recipient under a QMSCO, the child's appointed guardian will receive a copy of all pertinent information provided to the eligible employee. In addition, should the eligible employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

TERMINATION OF PARTICIPATION

Your eligibility for Plan benefits terminates on:

- Employee: the last day of the pay period (bi-weekly or semi-monthly) in which your termination from employment falls.
- Dependent Child: Midnight on the date of 26th birthday, or first day of pay period for which premiums are not paid, whichever is earlier. For children age 26 and 27 the date which they are no longer eligible or the first day of the pay period for which premiums are not paid.
- Termination of COBRA due to the end of coverage period or reasons described in the COBRA section of .

Except that you have the right to continue your health benefits following the occurrence of certain "qualifying events" that would otherwise result in the loss of coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA CONTINUATION RIGHTS

COBRA is a federal law that allows plan participants to continue medical and dental coverage under specified circumstances where such group coverage would otherwise be lost. To continue coverage, you or your covered dependents must apply for continuation coverage and pay the required premium before the deadline for payment. COBRA coverage can be extended for 18, 29 or 36 months, depending on the particular "qualifying event" which gave rise to the right to continue coverage under COBRA. If you were covered under a full benefit package when the qualifying event occurred, you may elect the full package (including medical, drug, dental and vision).

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Employer's health Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse or domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Employer's health Plan is lost because of the qualifying event. Under the Employer's health Plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact Ohio University Human Resources for fee payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under Ohio University's health Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or domestic partner of a Subscriber, you will become a qualified beneficiary if you lose your coverage under Ohio University's health plan because any of the following qualifying events happens:

- Your spouse or domestic partner dies;
- Your spouse's or domestic partner's hours of employment are reduced;
- Your spouse's or domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse or domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse or your domestic partnership terminates.

Your dependent children will become qualified beneficiaries if they lose coverage under Ohio University's health Plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated or domestic partnership terminates; or
- The child stops being eligible for coverage under the health Plan as a "Dependent child."

When is COBRA Coverage Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the University has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the University, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then you must notify the University of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation or termination of domestic partnership of the Subscriber and spouse or domestic partner or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the University within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the University receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouse or domestic partner, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Subscriber, the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a covered Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the health Plan is determined by the Social Security Administration to be disabled and you notify the University in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation

coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the University. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Subscriber or former Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Employer's health Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your health Plan and your COBRA continuation coverage rights should be addressed to the University. For more information about your rights including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting Employer health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

BENEFITS DURING FAMILY AND MEDICAL LEAVE

If you are on a leave of absence approved by your employer and your leave is protected under the federal Family and Medical Leave Act (FMLA), you may continue all health benefits during such leave of absence. Contact the Human Resources Department for details on eligibility for, and terms and conditions of, an approved leave of absence, or if you want to request FMLA leave.

While an employee is on FMLA leave, Ohio University continue to pay its regular share of the medical and dental insurance premium (for individual or dependent coverage) up to a maximum of 12 weeks within a 12 month period. Benefits that are not continued during FMLA leave will be reinstated, with no waiting period or preexisting condition limitation, if the employee returns to work at the end of FMLA leave.

CONTINUING BENEFITS DURING MILITARY LEAVE

If you go on active duty in the U.S. armed forces, you will cease to be covered under the regular group health plan as of the end of the month in which you enter active military service. However, you have the following rights to continue coverage:

1. If your military leave period is less than 31 days, you have the right to continue medical coverage for yourself and dependents who were covered under our group medical plan for up to 31 days, at a cost of not more than the cost for a similarly situated active employee.
2. If the military leave period is more than 31 days, you are entitled to continue health coverage for yourself and your dependents who were covered under the group medical plan under the United States Employment and Reemployment Rights Act (USERRA). You may continue coverage under this Act for up to 18 months at 102% of the cost of the coverage. This continuation right is concurrent with any right to continue coverage under COBRA.

HOW THE PLAN IS ADMINISTERED

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is Anthem Blue Cross and Blue Shield and/or Express Scripts.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

Responsibility of Ohio University

Ohio University is responsible for:

1. determining the eligibility for and the amount of any benefits payable under the Plan; and
2. prescribing procedures to be followed and the forms to be used by employees pursuant to the Plan.

Ohio University also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Questions:

If you have any general questions regarding the Plan or if you have questions concerning eligibility for and/or the amount of any benefits payable under the Plan, please contact Human Resources.

Circumstances Which May Affect Benefits or Cause a Loss of Benefits

Your benefits will cease as described in the Termination of Participation section of this document, unless your health benefits are extended under a COBRA election.

Your and your dependent's benefits will cease if you fail to make the required contribution payments.

Other circumstances which can result in the termination of benefits are described in the plan document.

Amendment or Termination of the Plan

Your benefits will also cease upon the termination of the Plan. Ohio University, as your employer, reserves the right to terminate or amend the Plan at any time. Generally, the Plan may be amended or terminated by a written instrument signed by an executive officer of Ohio University and shall be effective as of the date specified therein.

No Contract of Employment

The Plan is not intended to be, and shall not be construed as constituting, a contract or other arrangement between you and Ohio University which confers any legal right for your continued employment by Ohio University. In addition, the Plan will not interfere with Ohio University's right to release you from employment.

CLAIMS PROCEDURE**Filing a Claim**

Anthem Blue Cross and Blue Shield and/or Express Scripts is responsible for evaluating all health benefits under the Plan. Accordingly, to obtain benefits, you or your Provider must complete, execute and submit to Anthem a written claim on the required claim form.

See the section of your Benefit Book entitled "How to File a Claim" for further information.

If Anthem or Express Scripts denies your claim, in whole or in part, you may receive a written notification citing the setting forth:

- The specific reason or reasons for the denial;
- Specific reference to pertinent Plan provision(s) on which the denial is based;
- A description of any additional material or information necessary for the claimant to perfect the claim for appeal, and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if you wish to appeal the determination.

Please refer to the section in the Benefit Booklet entitled, "Appealing a Denied Claim", for further information on claims appeals.

Post Mastectomy Reconstructive Surgery

This plan complies with Federal law requiring certain benefits to be provided in connection with a mastectomy. Please see the "Surgical Services" section of your benefit booklet for further information on this coverage.

Maternity Minimum Stay Provisions

This plan complies with the Newborns' and Mothers' Health Protection Act. Please see the "Maternity Services" section of the Benefit Booklet for information regarding minimum maternity lengths of stay.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

This employee benefit is a confidential assessment and referral program that assists with many personal issues. .

Eligibility

The EAP is offered to all full time and part time Ohio University employees (excluding student employees) and their eligible dependents.

Services Provided

The EAP offers support and focuses on solutions. If resolving a problem requires a referral for further counseling or to any other resource, the EAP counselor will make referral recommendations as well. Some of the areas that they are prepared to help you or your eligible dependents with are:

- care of the aged
- child care issues (day care, child abuse, etc.)
- legal and financial issues
- marital stress
- mental health
- substance/chemical abuse
- matters impacting a person's general welfare

Should you accept any referral recommendations made by the EAP, services will be provided in accordance with the existing provisions of the Plan and the coverage you select. **In instances where the recommended services are not eligible under your selected coverages, you will be responsible for the payment of any non-covered services.**

Confidentiality

The EAP program is designed to assist employees with their personal everyday problems. Any information you share with your EAP counselor is completely **confidential**. When you call, your identity will not be revealed to Ohio University or its employees. For 24-hour information, please contact Employee Assistance providers at: 800-227-6007.

When calling, remember to identify yourself as an Ohio University employee or dependent. Any time, day or night, seven days a week, a counselor will be available to assist you or your eligible dependents.

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections including:

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions;

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary

plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your groups health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage, if the Plan imposes a pre-existing condition exclusion.

The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights.

If your claim is denied in whole or in part, you may receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim.

There are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the material and pay up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

General Information

Name of the Plan:	Ohio University AFSMCE PPO Plan
Plan Sponsor:	Ohio University 169 West Union Street Athens, Ohio 45701 (740) 593-1636
Type of Plan:	Hospital, Medical Surgical, Prescription Drug, Dental and Vision, and Employee Assistance Plan
Type of Administration:	The health care benefits are provided under a contract entered into between Ohio University and Anthem Blue Cross and Blue Shield, , Express Scripts,BMA Impact, Vision Service Plans
Plan Administrator:	Anthem Blue Cross and Blue Shield, Express Scripts, BMA Impact, Vision Service Plans
Plan Fiscal Year:	July 1 to June 30
Plan Contributions:	Contributions necessary to fund the plan are provided by Ohio University and its employees. Ohio University will contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan.

Future of the Plan:

Benefits under this Plan are paid for on a year-to-year basis, but Ohio University reserves the right to change or end the Plans at any time. Ohio University's decision to change or end the Plan may be due to changes in federal or state laws governing welfare benefits, the requirements of the Internal Revenue Code , the provisions of a contract or policy involving an insurance company, or any other reason. A Plan change may transfer Plan assets and debts to another plan or split the Plan into two or more parts. If Ohio University does make a change like this or decides to end the Plan, it may decide to set up different plans providing similar or identical benefits or it may decide not to provide benefits at all.

If the Plan is ended (or if there is a transfer of assets and debts or a plan split-up), you will not be vested in any Plan benefits or have any further rights (other than payment of covered expenses you had before the Plan ended.)